

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED APR 17 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		c. CITY OR TOWN <u>Independence</u>	
Length of stay in 1b <u>22 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1414 W. Short</u>		d. STREET ADDRESS (If outside, give location) <u>1414 W. Short</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Henry</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1888</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Minister</u>	
11. BIRTHPLACE (City and state or country) <u>Elmwood, Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Gray</u>		13b. MOTHER'S MAIDEN NAME <u>Kate McKinley</u>	
14. NAME OF HUSBAND OR WIFE <u>Ruth Gray</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ruth Gray</u> Address <u>Indep. Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mch</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic + hypertensive cardiovascular disease</u>		DUE TO (c) <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>peripheral vascular insufficiency</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>12:15</u> a.m. p.m. Month, Day, Year <u>4/17/62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1414 W. Short</u>	
20f. CITY, TOWN, OR LOCATION <u>Independence, Mo</u>		COUNTY <u>Jackson</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>4/17/62</u> to <u>4/17/62</u> and last saw her alive on <u>4/11/62</u>		Death occurred at <u>12:15</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Vance E. Lueb, M.D.</u>		22b. ADDRESS <u>10901 winner Rd Independence, Mo</u>	
22c. DATE SIGNED <u>4/11/62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>4-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>	
23d. LOCATION (City, town, or county) <u>Independence</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Roland R. Speaks</u>		ADDRESS <u>Indep. Mo. 4-12-62</u>	
25. DATE RECD. BY LOCAL REG. <u>4-12-62</u>		26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 30 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

4-12-62